

IPDR6702		NORTH CAROLINA			PAGE: 1		
RUN DATE: 01/08/2006		IPRS CHECKWRITE SUMMARY REPORT					
		CHECKWRITE DATE: 01/10/2006					
		FINANCIAL PAYER: NCDMM					
						TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		TWC	TOTAL	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	CLAIMS
						FINALIZED	PAID
3404901	SMOKY MOUNTAIN H/DD/SAS	8599	6	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.			
		21	2	DUPLICATE OF CLAIM-SYSTEM	0	8	8
							0
3404904	WESTERN HIGHLAN DS LME	0	0	*** NO DATA TO REPORT ***			
		0	0		0	0	13
							13
3404910	PATHWAYS	8534	71	SERVICE FACILITY LOCATION IS N OT A VALID IPRS ATTENDING PROVIDER. PLEASE VERIFY THE F			
		8518	29	CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE	2	193	4181
							3962
		8622	25	60 RESIDENTIAL LEVEL II TREATM ENT RECEIVED, PA IS REQUIRED FOR ADDITIONAL SERVICE.			
3404912	CATAWBA COUNTYM ENTAL HEALT	8599	15	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.			
		8931	10	AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS.	15	57	1863
		8645	9	CLAIM DENIED MAXIMUM ALLOWED 2 6 OCCURRENCES PROCESSED AND PAID, PA IS REQUIRED.			1806
3404913	MECKLENBURG COM ENTAL HEALT	8599	40	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.			
		0	0		0	40	155
							115
3404916	CROSSROADS BEHA VIOAL HEAL	21	391	DUPLICATE OF CLAIM-SYSTEM			
		8952	17	CLAIM DENIED DUE TO AGE RESTRI CTIONS FOR TARGET POPULATION	0	433	1806
		8599	10	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.			1373
3404917	CENTERPOINT HUM AN SERVICES	8599	263	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.			
		8518	60	CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE	46	463	3963
							3500
		79	52	THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN			
3404918	ROCKINGHAM CO M ENTAL HEALT	0	0	*** NO DATA TO REPORT ***			
		0	0		0	0	0
							0

PROVIDER NUMBER	PROVIDER NAME	HIGH DENIAL EOBS	NUMBER OF DENIALS	DESCRIPTION	TMC DENIALS	TOTAL DENIALS	TOTAL CLAIMS FINALIZED	TOTAL CLAIMS PAID
3404919	GUILFORD CO MEN TAL HEALTHC	8599	161	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		8931	7	AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPFS.	15	195	3274	3179
		3404	6	SEVERE DUPLICATE: SAME ATTD PR OV/PCODE/TOS/DOS/MOD				
3404920	ALAMANCE CASWEL L AREA MH D	8505	5115	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET				
		79	135	THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN	5	5268	5953	685
		8599	11	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
3404921	ORANGE PERSON C HATHAM AREA	5312	915	PRIOR AUTHORIZED DOLLARS EXCEE DED				
		8505	97	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET	7	1302	2204	902
		8800	77	FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON FUTURE RA'S.				
3404922	THE DURHAM CENT ER	8505	275	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET				
		8329	20	CLAIM DENIED ATTENDING PROVIDE R CANNOT BE THE SAME AS THE LMA	0	299	299	0
		8535	4	SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT				
3404923	FIVE COUNTY MH	11	216	CLIENT NOT ELIGIBLE ON SERVICE DATE				
		8599	42	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	0	316	1354	1038
		21	18	DUPLICATE OF CLAIM-SYSTEM				
3404925	SANDHILLS CENTE R FOR MH/DD	8505	374	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET				
		21	257	DUPLICATE OF CLAIM-SYSTEM	72	1303	8896	7593
		8599	253	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
3404926	SOUTHEASTERN RE G MENTAL HL	8599	102	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		11	60	CLIENT NOT ELIGIBLE ON SERVICE DATE	12	242	3720	3478
		120	35	CLIENT ID NUMBER MISSING OR IN VALID. ENTER CTD AND SUBMIT AS A NEW CLAIM				

PROVIDER NUMBER	PROVIDER NAME	HIGH DENIAL EOBS	NUMBER OF DENIALS	DESCRIPTION	TMC DENIALS	TOTAL DENIALS	TOTAL CLAIMS FINALIZED	TOTAL CLAIMS PAID
3404927	CUMBERLAND CO M HC	79	12	THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN				
		8599	8	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	0	30	1452	1422
		191	4	CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME				
3404929	LEE HARNETT MH/ DD/SAS	0	0	*** NO DATA TO REPORT ***				
		0	0		0	0	0	0
3404930	JOHNSTON COUNTY MNTL HLTHC	8505	5	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET				
		8800	1	FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON FUTURE RA'S.	0	6	6	0
3404931	WAYNE CO HUM SVC BILLING OF	8599	30	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		11	4	CLIENT NOT ELIGIBLE ON SERVICE DATE	5	45	395	350
		21	3	DUPLICATE OF CLAIM-SYSTEM				
3404933	SOUTHEASTERN CT R FOR MH/DD	8599	137	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		8621	68	60 RESIDENTIAL LEVEL III TREAT MENT RECEIVED, PA IS REQUIRED FOR ADDITIONAL SERVICE.	5	314	3727	3413
		8000	59	NO RATE AVAILABLE ON FILE TO P RICE THIS CLAIM DETAIL				
3404934	ONSLow CARTERET REHAV HEAL	11	276	CLIENT NOT ELIGIBLE ON SERVICE DATE				
		8952	28	CLAIM DENIED DUE TO AGE RESTRI CTIONS FOR TARGET POPULATION	0	336	800	464
		8599	14	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
3404935	WAYNE CO MENTAL HEALTH CTR	0	0	*** NO DATA TO REPORT ***				
		0	0		0	0	0	0
3404936	WILSON-GREENE M ENTAL HEALT	8599	125	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		8534	60	SERVICE FACILITY LOCATION IS N OT A VALID IPRS ATTENDING PROVIDER. PLEASE VERIFY THE F	13	213	1126	913
		8518	10	CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE				
3404937	EDGEcombe NASH MNTL HLTH C	8518	455	CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE				
		79	50	THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN	1	573	4215	3642
		21	29	DUPLICATE OF CLAIM-SYSTEM				

PROVIDER NUMBER	PROVIDER NAME	HIGH DENIAL EOBS	NUMBER OF DENIALS	DESCRIPTION	TMC DENIALS	TOTAL DENIALS	TOTAL CLAIMS FINALIZED	TOTAL CLAIMS PAID
3404938	VGFW DBA RIVERS TONE COUNSE	0	0	*** NO DATA TO REPORT ***				
		0	0		0	0	0	0
3404939	NEUSE MENTAL HE ALTH CENTER	8599	102	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		21	28	DUPLICATE OF CLAIM-SYSTEM	0	133	884	751
		10	1	DIAGNOSIS OR SERVICE INVALID F OR CLIENT AGE. VERIFY CID, DIAGNOSIS, PROCEDURE CODE FOR				
3404941	PITT CO MH/DD/S AS CENTER	8599	104	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		191	41	CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME	3	150	1214	1064
		8935	3	ASTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS.				
3404942	ROANOKE CHOWANH UMAN SERVIC	0	0	*** NO DATA TO REPORT ***				
		0	0		0	0	97	97
3404943	ALBEMARLE MENTA L HEALTH CE	21	591	DUPLICATE OF CLAIM-SYSTEM				
		79	65	THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN	48	764	1416	652
		8935	26	ASTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS.				
3404944	EASTPOINTE HUMA N SERVICES	8599	284	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		21	174	DUPLICATE OF CLAIM-SYSTEM	41	782	6206	5424
		79	110	THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN				
3404946	FOOTHILLS AREAM ENTAL HEALT	21	1371	DUPLICATE OF CLAIM-SYSTEM				
		24	551	PROCEDURE CODE, PROCEDURE/MODI FIER COMBINATION OR PROCEDURE CODE/TYPE OF SERVICE COMBINATI	25	2081	2427	346
		8534	73	SERVICE FACILITY LOCATION IS N OT A VALID IPRS ATTENDING PROVIDER. PLEASE VERIFY THE F				
3404957	TIDELAND MENTAL HEALTH CTR	8536	71	ATTENDING PROVIDER TYPE AND SP ECIALTY COMBINATION IS NOT VALID FOR SUBMITTED BILLING PR				
		8518	59	CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE	8	184	653	469
		191	25	CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME				

PROVIDER		HIGH DENIAL	NUMBER OF		TMC	TOTAL	TOTAL	TOTAL
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404979	NEW RIVER AREAM	21	8	DUPLICATE OF CLAIM-SYSTEM				
	H/DD/SA PRO							
		8518	4	CLAIM DENIED, SUBMITTED BEYOND	3	19	4306	4287
				FILING TIMELIMIT. PRIOR				
				FISCAL YEAR EOS (JULY 1 - JUNE				
		8599	4	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				